



Next STEPs Participant Information

Name:					
Address:					
City:		State:		Zip:	
Day Phone:		Evening Phone:			
Email:					
Ethnicity (optional):					

Are you a parent of a child with disabilities?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Disability: _____
If yes, what is the age and grade of your child?	Age		Grade
Are you a professional?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
If yes, what is your role?			

How did you hear about the training?

What experiences and strengths will you bring to this class?
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Do you have experience on school, district, regional or state level committees or groups? If so, please explain

How do you hope to use the information you will receive at the training?
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Once training is complete, would you be interested and able to (please circle):

- | | |
|--------------------------------|--|
| Conduct parent trainings | Represent CPAC at outreach events |
| Help other parents one-on-one | Share your story with student teachers |
| Serve on a statewide committee | Start/run a parent support group |

Please be sure to submit by deadline!

Please use the reverse side for any additional information you would like to provide. Please return to:
CPAC, 338 Main Street, Niantic, CT 06357, email to jhampton@cpacinc.org
fax (860) 739-7460